



MeCMS LIMITS FUNCTIONALITY

The June 2008 repair initiative is expected to correct some of the inaccuracies that currently exist in MeCMS regarding the application of limits to services as defined in MaineCare Policy. Over the past several months, this upgrade has been developed and tested. However, the limit repairs will not address every outstanding MeCMS claims payment issue. Please note, there are no limits adjustments identified to be state or system initiated. The following is a summary of the changes that will be effected by this initiative and instructions on how to submit claims to minimize errors and denials.

Providers who have held claims due to limits payment issues are advised to submit these claims in small quantities initially and to continue to increase the volume of claims as these process appropriately.

Unless previously “voided” in MeCMS, claims beyond the timely filing dates must be submitted on paper with a justification for timely filing. For example, “W125” claims, Personal Support Services, will be accepted as justified claims based on MeCMS’ previous inability to process them correctly. Please contact Provider Relations at **1 (800) 321-5557, Option 8**, for assistance in following timely filing procedures. Rules regarding time limits for submission of claims are listed in Chapter I of the MaineCare Benefits Manual, *General Administrative Policies and Procedures*, pages 37-38, at <http://www.maine.gov/sos/cec/rules/10/144/ch101/c1s.doc>.

Service limits are defined in Chapter II of the MaineCare Benefits Manual, “*Specific Policies by Service*,” available at <http://www.maine.gov/sos/cec/rules/10/ch101.htm>. Due to exceptions to limits established in some MaineCare Policies, not all limits can be programmed to automatically reject claims beyond established limits. These are referred to as “soft limits.” An example of this is the following Psychological Services limit:

“Reimbursement for family psychotherapy services shall not exceed ninety (90) minutes per week except for: 1. Members in an inpatient psychiatric facility, for whom service shall be provided in accordance with the plan of care; 2. Members who are in family therapy that is designated for the purpose of treatment for trauma, for example: sex abuse treatment, or domestic abuse treatment; 3. Children receiving family therapy that is designated for the purpose of treatment for attention deficit or severe childhood trauma as defined above; 4. Members who are in a family therapy that is designated for the purpose of sex offender treatment; or 5. Members who are receiving partial hospitalization services.”

More concrete limits programmed in MeCMS are referred to as “hard limits.” An example of this is the following dental service limit: *“Pit and fissure sealants are reimbursable for permanent teeth, once every three (3) years per member per provider, and once per lifetime for deciduous (baby) teeth.”* Most “hard limits” that did not process correctly in the past will now be applied to claims as they are processed. Such claims that may have paid in the past should no longer pay once the limit has been met.

There are some “hard limits” from recently changed MaineCare Policy, however, that have not yet been implemented in MeCMS. Examples of this are limits outlined in Section 21, “*Home and Community Benefits for Members with Mental Retardation or Autistic Disorder*,” and Section 29, “*Community Support Benefits for Members with Mental Retardation and Autistic Disorder*.” These will not be implemented until they can be tested later this year. For this reason, providers are reminded of their responsibility to follow limits rules and to return overpayments of claims beyond limits as listed in the applicable MaineCare policy.

Specific limits information:

- For services billed with limits based on a time span of a calendar week¹ (Sunday – Saturday) or calendar month, the “from” and “to” dates billed should not exceed the time span of the limit. For example: If the service billed is based on a calendar month limit, the “from” date must start no earlier than the first of the month and the “to” date can be no later than the last day of the month. If a member loses eligibility, providers should bill through the last date of eligibility for services subject to monthly limits.
- For CMS-1500, Professional Claims, only: For services billed with limits based on a **daily time span**, the number of days must equal the number of units billed on the line. If the line has a date range of five (5) days, the unit value should be “5.” Only services performed on consecutive dates of service can be billed on the same line. For example, if services are rendered on the 1st through the 3rd of the month and then again on the 5th through the 6th, the services should be billed on two (2) separate lines. Line one (1) would list the 1st through the 3rd for “3” units and line two (2) would list the 5th through the 6th for “2” units.
- Once this repair initiative has been deployed to production, a minimum of a two-week period will be required to validate the processing of claims with associated limits. After July 14, 2008, providers may begin to submit the claims with previous billing issues related to limits. For example, W125, Personal Support Services, where one day of service has paid and the next week was suspended and has since been denied; providers should then rebill these denied claims for correct processing to payment.
- Claims Adjustment Reason Codes (CARC): Due to changes implemented as part of the “Limits Functionality Initiative,” when a cutback is applied to a claim line or a claim line is denied due to the application of a limit, the following error codes will be applied, as appropriate: CARC 119: “*Benefit maximum for this time period or occurrence has been reached.*” (In the past, CARC 35 was used in these situations.) CARC 35: “*Lifetime benefit maximum has been reached.*” Remittance Advices (RAs) and Electronic Remittance Advice (835s) will display CARC 119 after June 23, 2008.
- If you are a provider who has been previously issued a final audit cost settlement, the Limits functionality may result in subsequent changes to the paid claims data in previously issued final audit cost settlements. It may be necessary for the Office of Audit to reopen a previously issued final audit cost settlement report. For more information on the Principles of Reimbursement, please refer to Chapter III, *Allowances for Services*, at <http://www.maine.gov/sos/cec/rules/10/ch101.htm>
- Reminder: Until further notice, please do not submit limits adjustments to legacy claims (pre-MeCMS, 12-digit TCNs). Please refer to the adjustments instructions as they apply to Limits claims submission, located at http://www.maine.gov/bms/pdfs_doc/mecms/news_can_use/provider_instructions_adjustments20080320.doc.

We invite you to visit our web site http://www.maine.gov/bms/member/innerthird/news_page.shtml for late-breaking news and to join our ListServ <http://mailman.inform.org/mailman/listinfo/provider/> to receive up-to-date information regarding MeCMS repairs. Also, please feel free to contact Provider Relations at **1 (800) 321-5557, Option 8**, if you have questions regarding the limits initiative. We appreciate your patience, cooperation and continued support. Thank you!

¹ Unless otherwise specified in MaineCare Policy, a “week” or a “month” is interpreted as a “calendar week” or a “calendar month,” respectively.